STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005053	A. BUILDING: _____ B. WING _____	01/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL HOSPITAL OF SOUTH BEND	615 N MICHIGAN ST SOUTH BEND, IN 46601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for investigation of two hospital licensure complaints. Complaint Numbers: IN00150677: Unsubstantiated; lack of sufficient evidence. Deficiency cited unrelated to the allegations. IN00159509: Unsubstantiated; lack of sufficient evidence. Facility Number: 005053 Date: 1/12/15 and 1/13/15 Surveyor: Linda Plummer, R.N., Public Health Nurse Surveyor QA: claughlin 02/26/15	S 000		
S 912	410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-15-6 (a)(2)(B)(i)(ii) (iii)(iv)(v) (a) The hospital shall have an organized nursing service that provides twenty-four (24) hour nursing service furnished or supervised by a registered nurse. The service shall have the following: (2) A nurse executive who is: (B) responsible for the following: (i) The operation of the services, including, but not limited to, determining the types and numbers of	S 912		6/3/15

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S 912	Continued From page 1 nursing personnel and staff necessary to provide care for all patient care areas of the hospital. (ii) Maintaining a current nursing service organization chart. (iii) Maintaining current job descriptions with reporting responsibilities for all nursing staff positions. (iv) Ensuring that all nursing personnel meet annual in-service requirements as established by hospital and medical staff policy and procedure, and federal and state requirements. (v) Establishing the standards of nursing care and practice in all settings in which nursing care is provided in the hospital. This RULE is not met as evidenced by: Based on policy and procedure review, medical record review, and interview, the nurse executive failed to ensure that patients admitted with seizure or suicide issues, and assessed for fall risk were added to the "Problem List" for these issues involving 2 of 5 patients (#1 and #3); failed to ensure that the MHTs (mental health techs) were made aware of individual precautions of patients with the lack of notation on their "patient monitoring record" form for 5 of 5 patients (pts. #1 through #5); and failed to ensure that nursing staff completed NGASR (Nursing Global Assessment Suicide Risk) assessments, as per protocol and expectation for 4 of 5 patients (#2, #3, #4, and #5). Findings: 1. Review of the policy titled "Precautions", no	S 912		

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S 912	Continued From page 2	S 912		

policy number, effective date 4/7/11, indicated:
a. Under "Procedure", it reads: "1. Obtain a doctor's order to institute or discontinue each specified precaution. 2. The R.N. may institute a precaution when there is immediate concern for patient safety and a physician's order must follow as soon as possible. 3. All patients are reviewed daily by the R.N. and at staffing meetings to assess the need for continuation or discontinuation of precautions. 4. The specific precautions are documented on: a. Patient Graphic Sheet...b. Patient Monitoring record...c. Nursing Report Board...d. Clinical Progress Note;...5. The night shift will initiate a Patient Monitoring Record for the next 24-hour period commencing with 0001, including the patients' room number and the specific precautions and place the record on the designated clipboard...".
b. On page 4 under section "D. Seizure Precautions", it reads: "Seizure Precautions - are utilized if the patient presents with a history of seizures. The physician's order should specify the type and cause of the seizure the patient has experienced...".
c. On the last page of the policy, it reads: "...A. Documentation Procedure:...3. All areas of the Patient Monitoring Record must be completed accurately and thoroughly including: name, date, reason, precautions and frequence. a. The nurse is to document at the beginning and end of each shift...".

2. The NGASR area of the EMR (electronic medical record) is an area that is to be completed on admission and as part of nursing's "Daily Assessment".

3. Review of closed medical records indicated:
a. Pt. #1 was a 74 year old admitted on 1/20/14 after being hospitalized at the acute care hospital

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S 912	Continued From page 3	S 912		

with "...new onset seizure...", per the admission history and physical (H & P) of 1/21/14 at 8:33 AM. Other information in the medical record included:

A. In the "assessment" portion of the H & P, it reads: "1. Seizures as mentioned. Medication adjustments and per (sic) psychiatry. We will follow [pt] closely for seizure precautions...".

B. Seizure precautions were ordered 1/18/14 at the local acute care hospital, but had a discontinued date and time of 1/20/14 at 6:01 PM, when the patient was discharged to the gero psych/behavioral health unit.

C. There was no order by the physician for seizure precautions when admitted to the gero psych unit.

D. The patient scored at a level to be considered a fall risk (3, 4, 5 and 6). (Per the Conley scale, a score greater than 2 would indicate the patient is a fall risk.)

E. Nursing documentation indicated the patient was a fall risk.

F. The combination treatment plan/nursing care plan lacked listing seizures as a health problem for care planning, and lacked care planning related to the patient's risk for falls.

G. The Patient Monitoring Record forms for 1/20/14 to 1/26/14 (the day of discharge) were lacking notation of Seizure Precautions and Fall Precautions.

H. The patient was transferred back to the local hospital ED (emergency department) after a seizure at 10:15 AM on 1/26/14. (Seizure precautions were not ordered until 1/26/14, when the patient actually had a seizure at this facility.)

b. Pt. #2 was a 75 year old admitted on 1/12/14 with major depression with psychotic features. Per SW (social worker) notes of 1/13/14 at 4:11 PM, the patient had been found by a family

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member in their car (in the garage) with the motor running in a suicide attempt. A letter had been left on a table indicating the patient was "...sad, very tired, ready to go, and doesn't want to live anymore...". Further information in the medical record included:

A. A nursing order at 12:36 PM on 1/12/14 was for suicide precautions "...secondary to charted result on NGASR assessment". (This order was discontinued at 2:15 PM on 1/13/14 by another nurse and never written by a physician.)

B. Per the NGASR completed at 9 AM on 1/13/14, the patient scored 14, a high risk for suicide.

C. Per the NGASR form, if the patient scored >6, the NGASR is to be completed daily.

D. There were no other NGASR assessments completed until the day the patient was discharged, 1/21/14, when they scored at 10.

E. The Patient Monitoring Record forms for 1/12/14 to 1/21/14 were lacking notation of Suicide Precautions.

c. Pt. #3 was an 89 year old admitted on 1/20/14 with a diagnosis of major depressive disorder with psychotic features. Further documentation in the medical record included:

A. Per the NGASR completed on 1/20/14, the patient scored 11, a high risk for suicide.

B. Per the NGASR form, if the patient scored >6, the NGASR is to be completed daily.

C. The patient scored at a level to be considered a fall risk (2 on 1/20/14; 3 on 1/21/14; 6 on 1/23/14; 4 on 1/27/14). (Per the Conley scale, a score greater than 2 would indicate the patient is a fall risk.)

D. The combination treatment plan/nursing care plan lacked care planning related to the patient's risk for falls.

E. The Patient Monitoring Record forms for

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S 912	Continued From page 5 1/20/14 to 2/25/14 were lacking notation of Suicide Precautions or Fall Precautions. 4. Review of open medical records indicated: a. Pt. #4 was a 58 year old admitted on 1/6/15 with bipolar currently depressed with no psychosis, after presenting to the acute care hospital ED with "thoughts of suicide, no plan", per the admission psychiatric exam/evaluation. Further documentation in the medical record included: A. A physician order was written on admission at 6:14 AM on 1/6/15 for suicide precautions. B. Per the NGASR completed on 1/6/15, the patient scored 16, a high risk for suicide. C. There were no NGASR assessments since admission. D. The Patient Monitoring Record forms for 1/6/15 to 1/13/15 were lacking notation of Suicide Precautions for 4 days since admission. b. Pt. #5 was a 78 year old admitted on 1/11/15 with suicidal precautions ordered at 4:03 AM on 1/11/15. Further documentation in the record included: A. Per the NGASR completed on 1/11/15, the patient scored 16, a high risk for suicide. B. No NGASR was done on 1/12/15, or today, 1/13/15, so far. C. The Patient Monitoring Record form for 1/11/15 was lacking notation of Suicide Precautions 5. At 11:40 AM on 1/13/15, interview with staff member #52, the medical records staff member, indicated: a. Seizure precautions were ordered at the hospital for pt. #1 and should be "good", also, for this facility, but were found to have been discontinued at the time of discharge from the	S 912		

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S 912	Continued From page 6 hospital and not re-ordered upon admission to the gero psych unit. b. There was no order for suicide precautions for pt. #2. 6. Interview with staff member #43, the director of clinical services, at 11:45 AM on 1/13/15, indicated: a. A new order for seizure precautions should have occurred upon admission for pt. #1. b. Nursing can write a "communication" to the physician requesting a precaution, especially after doing an assessment that indicates the patient is at risk, such as for falls, seizures, suicide, and others. But, it is up to the physician to then write the order based upon the nurse's recommendation in the "communication". c. Nursing staff is not completing NGASR assessments, as per the document's instructions that with a score >6 they are to be completed on a daily basis. d. There is no specific policy related to the NGASR scoring on admission and daily by nursing staff, it is part of the EMR that is to be completed as part of nursing assessment. e. Nursing is not following policy in noting patient precautions, to alert MHTs for better patient care, on the Patient Monitoring Record forms. f. Per the "Fall Risk" policy, patients scoring greater than a 2 on the Conley will result in an automatic addition of Fall risk to the "Problem List". It is at the nurses' discretion to put a patient on the "Problem List" for falls if they score at 2 or lower. g. The "Interdisciplinary Plan of Care and Coordination" policy does not specifically indicate that seizure, suicide and fall precautions are to be listed on the care plan, but that is the expectation at this facility.	S 912		

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